

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 05/21/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/03/2007
NAME OF PROVIDER OR SUPPLIER  HRDI OF THE DISTRICT OF COLUMBIA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1419 VAN BUREN STREET, NW WASHINGTON, DC 20012	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS  A recertification survey was conducted from April 30, 2007 through May 3, 2007. A random sample of three clients was selected from a client population of six clients with varying degrees of disabilities.  The survey was completed using the full survey process. The findings of this survey were based on observations at the group home and three day program, interview with direct care staff and management, and a review of the habilitation and administrative records to include the review of unusual incident reports.	W 000		
W 104	483.410(a)(1) GOVERNING BODY  The governing body must exercise general policy, budget, and operating direction over the facility.  This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Governing Body failed to provide general operating over the facility.  The findings include:  1. Interview with the QMRP and review of the unusual incident reports on April 30, 2007 at approximately 3:00 PM revealed that the facility failed to demonstrate that a investigation had been conducted to determine the circumstances surrounding the incident which occurred on November 10, 2006. The incident report described that Client #1 and #3 were involved in a vehicle accident with direct care staff driving the company vehicle. Both client received injuries as a result of the accident and were taken to a local	W 104	W 104  1. The QMRP and Incident Management Team have completed the incident investigation follow-up for the report dated November 10, 2006 which involved client #1 and client #3. (See Attached Follow-Up form) Additionally on 5/29/07 the QMRP has been in-serviced by the Incident Management Coordinator as to the proper procedures for reporting, investigating and following-up on all incidents. (See Attached Sign-In sheet)	5/29/07 and ongoing

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DEPARTMENT OF HEALTH  
HEALTH REGULATION  
ADMINISTRATION  
2007 MAY 30 A 8:58  
After 5pm

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 hospital emergency room for evaluation and treatment. There was no evidence that the governing body had secure a copy of the police report and ensure that a internal investigation was conducted to determine the cause of the accident.  2. Observation of the environment on April 30 ,2007 through May 2, 2007 revealed the carpet through-out the facility was damaged (torn), which could be a potential safety hazard to the client while ambulating in the facility.  a) The front living room carpet was torn.  b) The office carpet was cover by a throw rug. Client #6's foot got caught in the throw. The client tripped but did not fall.  c) The foyer on the main level had a large tear in the carpeting.  d) The carpet in the second level hallway was torn.  The governing body failed to ensure a safe environmental conditions for the client's residing in this facility.	W 104	W 104  2. A. The throw rug covering the office carpet was removed during the survey process and the carpet is scheduled to be replaced on 7/26/07.  (2 B & C ) The Carpet has been scheduled for replacement throughout the entire facility on July 26, 2007. Furthermore the Home manager will complete weekly home inspection and complete maintenance request forms whenever there are any environmental concerns. Subsequently the maintenance department will complete quarterly walk-thru of all HRDI homes to ensure safe environmental conditions for all clients.	07/26/07	07/26/07
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.  This STANDARD is not met as evidenced by: Based on review of the facility's policy of incident management and interview the facility failed to	W 149			

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W 149	Continued From page 2 report and the notify state agency all Unusual Incident and its related investigations.  The findings include:  Interview with the Qualified Mental Retardation Professional (QMRP) and record review on May 3 and 4, 2007 revealed that the facility failed to implement its written policies on reporting and investigation of there unusual incidents detailed below:  1. The facility failed to demonstrate that a investigation had been conducted to determine the circumstances surrounding the incident on April 9, 2007 in which Client #1 was observed by direct care staff with a scratch on her arm in her bed. According to further review of the usual incident report some pertinent details were missing as well.  2. The facility failed to demonstrate that a investigation had been conducted to determine the circumstances surrounding the incident report dated November 21, 2006, Staff received a call from the physical therapist reporting that Client #2 bumped into a tree while on a walk. Client #2 was later dropped off to the group home with a band aid on her left leg. There was no evidence that an investigation was conducted in accordance with the agency's policy on unusual incidents	W 149	W149  1. An investigation was completed on 5/5/07 to determine circumstances surrounding client #1's scratch on her arm. (See attached Investigation-Follow-up Form) Additionally, the Incident Management Coordinator will ensure that all incidents are thoroughly investigated in a timely manner and that all procedures are followed when reporting an incident by conducting quarterly audits of each facility's incident book to ensure that all incidents have been reported and investigated.  2. An investigation regarding client #2's injury during a PT session was investigated on 5/5/07. (See Attached Investigation Follow- Up form). On 5/29/07 the QMRP was in-serviced on the proper procedures for investigating & following-up of incidents. Annual Incident Management trainings will be on-going. The QMRP will review incident reporting procedures every 6 months during scheduled in-home trainings.	5/5/07 and Ongoing       5/29/07 and ongoing
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS  The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other	W 153		

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W 153	Continued From page 3 officials in accordance with State law through established procedures.  This STANDARD is not met as evidenced by: Based on staff interview, review of incident reports and the review of the incident management system, the facility failed to ensure all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source were reported immediately to the administrator or to other officials as required by State Law [22DCMR Chapter 35 - 3519.10] through established procedures for two of three clients in the sample. (Client's #1 and #3)  The findings include:  Review of the incident reports on May 1, 007, at 9:50 AM revealed the following incidents that had not been reported to the administrator and the Department of Health according to the District policy:  a. On April 9, 2007, Client #1 was observed with a scratch on her arm by direct care staff.  b. On December 4, 2006, Client #1 scratch Client #3 on her face. The UIR indicated that the nurse, house manager and QMRP was notified of this incident.	W 153	A. The QMRP and Incident Management Team have completed the incident investigation follow-up for the report dated November 10, 2006 which involved client #1 and client #3. (See Attached Follow-Up form) Additionally on 5/29/07 the QMRP has been in-serviced by the Incident Management Coordinator as to the proper procedures for reporting, investigating and following-up on all incidents. (See Attached Sign-In sheet) Additionally the administrator has reviewed the incident and signed the incident report form. The Incident Management Coordinator will ensure that all incidents, investigations and recommendations are reviewed and signed by the Administrator. As of May 30, 2007 it is also HRDI policy that all incidents and investigations be forwarded to our Corporate headquarters to be reviewed by the Chief Clinical Officer. W153  B. The QMRP and Incident Management Coordinator have reviewed the incident dated 12/4/06. (See attached Investigation follow-up form) Additionally the administrator has reviewed the incident and signed the incident report form. The Incident Management Coordinator will ensure that all incidents, investigations and recommendations are reviewed and signed by the Administrator. As of May 30, 2007 it is also HRDI policy that all incidents and investigations be forwarded to our Corporate headquarters to be reviewed by the Chief Clinical Officer.	5/29/07 and ongoing	
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS  The facility must have evidence that all alleged violations are thoroughly investigated.  This STANDARD is not met as evidenced by:	W 154		5/30/07 and ongoing	

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W 154	Continued From page 4 Based on interview and record review the facility failed to ensure all unusual incidences of injuries of unknown origin were thoroughly investigated.  The finding includes:  Review of the facility's Unusual Incident Reports log book on April 30, 2007 at approximately 3:00 PM revealed the following incidents and/or injuries of unknown origin which had not been investigated:  On April 9, 2007, Client #1 was in her bed and staff observed a scratch on Client #1's arm. The unusual incident did not indicate which arm the injury was observed. According to interview with the QMRP, Client #1 has a one to one assigned to provide support during waking hour. Review of the behavior support data and the shift communication log on April 2, 2007 did not evidence documentation that the scratch was a result of any the clients targeted behaviors. There was no evidence that an investigation was conducted to determine the cause of this scratch.	W 154	W154  The incident dated April 9, 2007 was investigated on May 5, 2007. (See Attached Investigation follow-up form) On 5/29/07 the QMRP was in-serviced on the proper procedures for investigating & following-up of incidents. (See Attached Sign-In)	5/29/07 and ongoing	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL  Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.  This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility Qualified Mental Retardation Professional (QMRP), failed to adequately monitor, integrate and coordinate each client's health and safety.	W 159			

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W 159	<p>Continued From page 5</p> <p>The findings include:</p> <p>1. Interview with the day program Case Manager on April 1, 2007 at approximately 1:15 PM revealed that Client #1 begin attending her day program on April 22, 2007. Her initial days to attended the program were on Tuesday and Thursday of each week. According to the day program Case Manager, she contacted the QMRP on April 24 2007 and propose that Client #1 attend the program 1/2 days from Monday through Friday to allow for greater benefit and experience.</p> <p>Later on the same day, interview with the facility's nurse provided an explanation of the intake process. Further interview revealed that Client #1 had an intake meeting for admission into this facility on April 17, 2007. According to the nurse the group home was to have sent the day program Client #1's current medical and background information to assist them with the assessment process. At the time of the survey none of this information had been forwarded to the day program.</p> <p>Later interview with the QMRP on April 2, 2007 at 10:00 PM revealed that the home was in agreement with the client schedule changed, and failed to ensure that the appropriate historical background documentation had been provided to the day program prior to client #1 starting the program.</p> <p>2. The QMRP failed to ensure that the facility's staff implemented the agencies incident management policy and procedures. [See W149]</p> <p>3. The QMRP failed to ensure that each client's</p>	W 159	<p>W159</p> <p>1. The LPN submitted all medical background information to the Day Program on May 3, 2007. The LPN and QMRP has scheduled a follow-up meeting with the Day program provider to ensure continuity of medical and programming services.</p> <p>2. The QMRP has been retrained on Incident Management procedures as of May 29, 2007. The QMRP and Incident Management Coordinator conducted a full incident management training with home manager and direct care staff on June 7<sup>th</sup>, 2007 at 12pm.</p> <p>3. On May 30, 2007 the QMRP has revised each client's activity schedule to reflect IPP objectives. The QMRP has scheduled an in-service for June 2, 2007 with direct support staff to review activity schedules and IPP goals.</p>	<p>5/30/07 and ongoing</p> <p>5/29/07 and ongoing</p> <p>5/30/07 and ongoing</p>	

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W 159	Continued From page 6 Individual Program Plan (IPP) objectives were incorporated in their individual activity schedules. [See W250]	W 159			
W 189	4. The QMRP failed to ensure that clients ensure storage space was clearly defined for each Client's personal possessions. [See W423] 483.430(e)(1) STAFF TRAINING PROGRAM  The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employees to perform his or her duties effectively, efficiently and competently.  The findings include:  The facility's direct care staff failed to ensure Client #1 received her prescribed diet texture at her dinner meal. [See W474]	W 189	W 189  The QMRP & Nursing Staff will ensure that all staff has been properly trained on Client # 1 prescribed diet texture, as well as all other client's prescribed diet textures in the facility, by the agency's Speech and Language Professional and Nutritionist. This training will be completed on 6/2/07. Regular training by nutritionist and SLP shall be conducted quarterly to reflect any changes that might occur to all clients' prescribed diet textures. The QMRP, HM, and nutritionist will randomly conduct monthly observations on food preparation and meal time protocols to ensure adherence to prescribed diet.	6/2/07 and ongoing	
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION  The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.  This STANDARD is not met as evidenced by: Based on observation, staff interview and record	W 250			

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W 250

Continued From page 7

review, the facility failed to ensure that each client's Individual Program Plan (IPP) objectives were incorporated in their individual activity schedules for one of the three clients in the sample. (Clients #1)

The finding includes:

Observation on April 30, 2007 between 4:00 PM to 6:30 PM at her residence and May 2, 2007 at approximately 9:45 AM at her day program revealed that the direct care staff were observed encouraging Clients #1 to participate in a variety of activities.

On April 30, 2007 the Qualified Mental Retardation Professional (QMRP) was interviewed to ascertain Client #1's daily activity schedule. The QMRP revealed that Clients #1 attends day program for 1/2 day and returns to the group home to participated in an alternative programming for the remainder of the day. According to the QMRP the client started attending this program two day a week on April 22, 2007. On April 28, 2007 her attendance schedule was changes to 1/2 days Monday through Friday to maximize her "experience and benefits" at the day program.

Review of the habilitation records on May 2, 2007 at approximately 2:30 PM failed to have current activity schedule. Review of the clients' IPP program books reflected a generic daily activity schedules. It was noted to reflected from the time period of 11:00 AM to 3:00 PM that the "Day Program Discharged". The activity schedule failed to indicate the day program attendance correctly and the alternative programming schedule being implemented at the group home

W 250

W250

Client # 1 IPP objectives were incorporated to reflect their individual activity schedule on May 30, 2007. Changes to the activity schedule for Client # 1 were made to reflect and address In-home programming upon returning from the Day Program Monday through Friday 12:30 pm to 3.00 pm.

5/30/07 and  
ongoing

Client #1 activity schedule was corrected on May 30, 2007 to reflect a half-day schedule five days per week and an alternative programming schedule is currently being implemented by the one to one to reflect In-home programming between the hours of 12:30 pm to 3.00 pm.

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W 250	Continued From page 8	W 250			
W 331	by the one on one between the hour of 12:30 PM to 3:00 PM . 483.460(c) NURSING SERVICES  The facility must provide clients with nursing services in accordance with their needs.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide each client with nursing services in accordance with their needs.  The findings include:  1. The facility's nursing staff failed to ensure that Client #1's background and current health care information was forwarded to the day treatment program upon admission. [See W104]  2. The facility's nursing staff failed to ensure that direct care staff provided appropriate diet texture as prescribed. [See W474]	W 331	W331  1. The LPN submitted all medical background information to the Day Program on May 3, 2007. The LPN and QMRP has scheduled a follow-up meeting with the Day program provider to ensure continuity of medical and programming services.  2. The QMRP & Nursing Staff will ensure that all staff has been properly trained on Client # 1 prescribed diet texture, as well as all other client's prescribed diet textures in the facility, by the agency's Speech and Language Professional and Nutritionist. This training will be completed on 6/2/07. Regular training by nutritionist and SLP shall be conducted quarterly to reflect any changes that might occur to all clients' prescribed diet textures. The QMRP, HM, and nutritionist will randomly conduct monthly observations on food preparation and meal time protocols to ensure adherence to prescribed diet.	5/03/07 and ongoing	
W 423	483.470(c)(2) STORAGE SPACE IN BEDROOMS  The facility must provide suitable storage space, accessible to clients, for personal possessions, such as TVs, radios, prosthetic equipment and clothing.  This STANDARD is not met as evidenced by: Based on observation and interview the GHMRP failed to ensure storage space was available and clearly defined for each Client's personal possession for two of the client residing in the facility. (Client's #5 and #6)	W 423		6/2/07 and ongoing	

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W 423	Continued From page 9  The finding includes:  The facility failed to have an effective system and adequate storage space to ensure each client's personal possession were made available.  Environmental walk-through on May 2, 2007 at 10:30 PM revealed that a variety of Client #5 and #6 clothing were commingled and stacked on a shelf in the closet. Further observation revealed that hanging clothes were not labeled and it was unclear who clothes belonged to whom.  Interview with the house manager revealed that the clothing were separated according to the name labels. The surveyor removed two hangers from the closet, one with a sweater and another a blouse. It could not be determination which of these items belong to either of the clients. At the time of the survey, there was no evidence a the facility clear identified each clients personal clothing and ensure access and adequate space for their personal clothing.	W 423	W423  As of May 20, 2007 the facility provided suitable storage space for all client's personal possession in the facility, in addition to clearly defining adequate storage space for Client's # 5 and #6 personal possessions. The facility has developed an effective system for adequate storage space by utilizing other areas unused in the facility for storage; in addition all clients have clearly defined markings on all articles of clothing and hangers in closets and chest to reflect each client's personal clothing.	5/20/07 and ongoing	
W 474	483.480(b)(2)(iii) MEAL SERVICES  Food must be served in a form consistent with the developmental level of the client.  This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to serve foods in a form consistent with dietary orders for one of the six clients residing in the facility. (Clients #1)  The finding includes:  The facility failed to ensure that Client #1 received	W 474	W 474  The QMRP and Nursing Staff will ensure that all staff including HM has been re-trained on Client # 1 prescribed diet texture, as well as all other client's prescribed diet textures in the facility, by the agency's nutritionist and SLP. This training will be completed on 6/2/07. Quarterly training by nutritionist and SLP shall continue to reflect any changes that might occur to all clients' prescribed diet textures. The QMRP, HM, and nutritionist will randomly conduct monthly observations on food preparation and meal time protocols to ensure adherence to prescribed diet.	6/02/07 and ongoing	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  05/03/2007
NAME OF PROVIDER OR SUPPLIER  HRDI OF THE DISTRICT OF COLUMBIA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1419 VAN BUREN STREET, NW WASHINGTON, DC 20012		
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W 474	<p>Continued From page 10</p> <p>food in a form consistent with their prescribed dietary needs as evidenced below:</p> <p>During dinner observations on April 30, 2007 at approximately 6:43 PM Client #1's was served her plate of food consisted of long shredded pieces of baked chicken breast, rice and mixed greens. The House Manager was observed placing several eating guidelines on the table next to the client's plates.</p> <p>Review of the eating guidelines revealed that Client #1's food texture was "finely chopped into pieces no larger than a size of a pea". On April 2, 2007 the nutritional assessment date 2/8/07 and the physician's order confirmed the eating protocol of a finely chopped diet.</p> <p>Review of the training manual indicated that the staff had been trained on diet orders on January 4, 2007 by the consulting Nutritionist. The training however was not effective as the client was not served the proper prescribed textured diet.</p>	W 474			

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1000	INITIAL COMMENTS  A recertification survey was conducted from April 30, 2007 through May 3, 2007. A random sample of three clients was selected from a client population of six clients with varying degrees of disabilities.  This survey was initiated as a full survey. The finding of this survey were based on observations at the group home and three day program, interview with direct care staff and management, and a review of the habilitation and administrative records to include the unusual incident reports on file.	1000			
1041	3502.2(a) MEAL SERVICE / DINING AREAS  Modified diets shall be as follows:  (a) Prescribed in the resident's Individual Habilitation Plan and the record of the prescription for the modified diet shall be kept in the resident's record;  This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that one on the residents in the sample receive her prescribed modified diet. (Resident #1)  The finding includes:  See Federal Deficiency Report W474	1041	1041  On May 3, 2007 Resident # 1 prescribed diet is has been placed in the individual's Habilitation plan and all other remaining records for the resident.	5/3/07 and ongoing	
1078	3503.6 BEDROOMS AND BATHROOMS  Closet space within the bedroom may be considered in calculating square foot minimums for bedrooms but shall be clearly divided for each resident.	1078			

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
STATE FORM

TITLE

(X6) DATE

6899

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If continuation sheet 1 of 8

## Health Regulation Administration

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1078	Continued From page 1  This Statute is not met as evidenced by: Based on observation and interview the GHMRP failed to ensure closet space was clearly defined for each resident.  The finding includes:  During the environmental walk-through on April 2, 2007 at 10:30 PM revealed that Client #5 and #6 clothing were stacked on the shelf in the clothes closet. Further observation revealed that clothing on the clothes hangers were not labeled. Additionally, Client #5 and #6 bedroom closet did not evidence a clear division of each client's personal clothing.	1078	1078  As of May 20, 2007 The GHMRP has made the necessary changes to provide clearly defined storage space for each resident.  As of May 20, 2007 both Client's #5 and #6 as well as all other clients in the home articles of clothing in closet has been clearly labeled and defined to reflect each client's ownership of personal clothing.	5/20/07 and ongoing  5/20/07 and ongoing	
1090	3504.1 HOUSEKEEPING  The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.  This Statute is not met as evidenced by: Based on observation during the environmental walk-through the GHMRP failed to maintain the facility in a safe, clean, orderly and sanitary manner as evidence by:  The findings include:  INTERIOR  1. The furnace room had parts and wiring stored near the furnace.	1090			

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1090	Continued From page 2  2. The stove storage drawer was broken and off track.  3. Old furniture and boxes were being stored in the furnace room.  4. Expired cans of boost plus were being stored in the basement.  5. Carpeting throughout the facility (i.e. living room, office, foyer and second level hall) was ripped and torn which could be a potential hazard.  6. The living room couch was missing a support cushion. The client appeared to have some difficulty finding the support when attempting to stand up from being seated on the couch.  7. The bathtub on the second level was dirty and was observed to have peeling paint.  8. The second floor rear exit door was observed to have a large space exposing the facility to the element and the weather stripping was worn.  <b>EXTERIOR</b>  1. The basement exit stairwell was dirty with leaves and debris.  2. The drainage at the bottom of the stairwell was clogged with dirt, leaves and debris.  3. The gutter in the rear of the facility had peeling paint.  4. The front porch support base had many loose bricks and crumbling cement around the entire	1090	1090  The interior and exterior of the facility will be maintained in a safe clean, orderly, attractive and sanitary manner and will be free of all accumulations of dirt, rubbish and objectionable odors on an ongoing monitored basis by QMRP and HM.  1. The parts and wiring were removed from furnace room on 5/4/07.  2. The stove storage draw was repaired by maintenance on 5/4/07.  3. Furniture and boxes were removed from furnace room on 5/4/07  4. Expired boost was removed from basement on 5/4/07.  5. Carpet throughout facility will be replaced on 7/27/07.  6. The living room couch has been ordered and will be delivered on June 15, 2007  7. The bathtub on second level of facility has been cleaned and will be re-glazed on June 10, 2007  8. The second floor rear exit door has been repaired from space exposed, and weather stripping replaced on 5/4/07.  1. Basement exit was cleaned and debris and leaves were removed on 5/4/07.  Drainage at bottom of the stairwell was cleaned remove dirt, leaves and debris on 5/4/07.	5/04/07 and ongoing  5/04/07 and ongoing  5/04/07 and ongoing  5/04/07 and ongoing  7/27/07 and Ongoing  6/15/07 and Ongoing  6/10/07 and ongoing  5/04/07 and ongoing  5/04/07 and ongoing  5/4/07 and Ongoing

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I 090	Continued From page 3 porch base near the top.	I 090	2. Gutter in the rear of the facility has been painted 5/4/07.	5/04/07 and ongoing	
I 095	3504.6 HOUSEKEEPING  Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident.  This Statute is not met as evidenced by: Based on observation and interview the GHMRP failed to lock caustic agents being stored.  The findings include:  During the environmental walk-through on May 2, 2007 at approximately 11:00 AM revealed the following:  Caustic agents were being stored in the basement near the washer and dryer opened and unlocked. Additionally, a variety of caustic agents were observed unlocked in a unsecured cabinet in the furnace room.	I 095	3. The front porch support base is scheduled for repair on 6/12/07.   1095  All poison and caustic agents have been stored in a locked storage bin out of reach from each resident in the facility. 5/4/07  As of 5/4/07 caustic agents have been removed from the basement near washer and dryer and is being stored in a locked storage bin away from residents in the facility.	6/12/07 and Ongoing   5/04/07 and ongoing   5/04/07 and ongoing	
I 203	3509.3 PERSONNEL POLICIES  Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter.  This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees annually.  The finding includes:  Review of the personnel files conducted on May	I 203	1203  As of May 29 <sup>th</sup> 2007 all job descriptions have been obtained and are being kept in the facility for review (12 direct care staff, QMRP and HM)	5/29/07 and ongoing	

PRINTED: 05/21/2007  
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I 203	Continued From page 4  2, 2007, revealed that GHMRP failed to provide evidence of current signed job descriptions for twelve (12) direct care staff, the House Manager and the QMRP.	I 203			
I 206	3509.6 PERSONNEL POLICIES  Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties.  This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current health certificates for all employees annually.  The findings include:  On May 2, 2007, review of the personnel records revealed that the GHMRP failed to show evidence of current health certification for the following:  - six direct care staff [REDACTED]; - the House Manager [REDACTED]; - the QMRP [REDACTED]; - the Social Worker; - the Pharmacist; - the PT; - the Psychiatrist; and the - the Psychologist.	I 206	1206  Each employee will provide a physician's certification annually that a health inventory was performed and that there is no health concerns that shall prohibit performance of duties required. On May 29, 2007 the HR department generated letters to each staff with outdated physician's certification. Staff has 14 days to submit updated health certificates or they will be placed on administrative leave until such time as they can obtain an updated certificate. The HR and QA department have developed a system of tracking expired certifications to ensure all staff are made aware of upcoming expiration dates for personnel documentation.  All current health certificates will be filed in the facility by June 8, 2007 for the following: -All direct care staff including: [REDACTED], [REDACTED], [REDACTED] -House Manager -QMRP -Social Worker -Pharmacist -Physical Therapist -Psychiatrist -Psychologist	5/29/07 and ongoing          6/8/07 and ongoing	

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I 222	Continued From page 5	I 222			
I 222	3510.3 STAFF TRAINING  There shall be continuous, ongoing in-service training programs scheduled for all personnel.  This Statute is not met as evidenced by: Based on observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs were conducted for all personnel.  The finding includes:  See Federal Deficiency Report Citation W189	I 222	1222  The agency, QMRP, and HM shall provide Monthly, quarterly and annual in-service training for all facility personnel. A copy of the training agendas and subsequent documentation and or materials will be kept in the training log at the facility. Annual Trainings are scheduled for June 18 <sup>th</sup> and 25 <sup>th</sup> for all staff.	6/25/07 and ongoing	
I 227	3510.5(d) STAFF TRAINING  Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents;  This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current training in CPR for employees.  The findings include:  On May 2, 2007, review of personnel records/training records revealed that the following ten direct care staff are without current CPR. ( [REDACTED] )	I 227	On June 2, 2007 the nursing staff will in-service all staff on proper procedures for infection control. Subsequent trainings shall occur quarterly and upon the admittance of new staff. An annual training for infection control will take place on June 18 and June 25, 2007.  1227  Staff personnel to include the following ( [REDACTED] ) will be trained in CPR during next scheduled CPR training dates for June 13, 2007.	6/25/07 and ongoing	
I 379	3519.10 EMERGENCIES  In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of	I 379		6/13/07 and ongoing	

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1379	<p>Continued From page 6</p> <p>Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, GHMRP direct support staff and the Qualified Mental Retardation Professional (QMRP) failed to implement the facility's incident management policies as written.</p> <p>The finding includes:</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and record review on March 7 and 8, 2007 revealed that the facility failed to implement it written policies on reporting and investigation of there UIR's detailed below:</p> <p>1. The facility failed to demonstrate that a comprehensive investigation had been conducted to determine the circumstances surrounding the incident dated April 9, 2007. Client #1 was observed by direct care staff in her bed with a scratch on her arm. The UIR did not completely provide the pertinent details in accordance with the agency's policy and no investigation was completed.</p> <p>2. The facility failed to demonstrate that a comprehensive investigation had been conducted to determine the circumstances surrounding the incident report dated November</p>	1379	<p>1379</p> <p>During or Annual Trainings on June 18<sup>th</sup> and 25<sup>th</sup> 2007 the entire HRDI personnel body will be retrained on proper notification procedures to the Department of Health Facilities Division of any other unusual incident with any resident's health, welfare, living arrangement, well being or in any way.</p> <p>1. The QMRP and Incident Management Coordinator has completed the incident investigation surrounding client # 1 incident on April 9<sup>th</sup> 2007. QMRP, HM, LPN and all direct care staff will be retrained on how to report unusual incidents by the agency's Incident Management Team on June 7, 2007; in addition, during the June 2, 2007 in-service all one to one staff shall be retrained on how to provide support during waking hours and proper documentation for all clients in the facility. Full record of training will be filed in facility.</p> <p>2. On May 5, 2007 the QMRP has followed-up with the agency's Incident Management Team to ensure that a complete investigation was conducted to determine the circumstances surrounding the incident report dated November 21, 2006 with Client #2. The facility will also be re-trained including QMRP, HM, LPN and direct care staff on the proper procedures on the agency's policy on unusual incidents on June 7, 2007. Full record of training will be filed in the facility. (See Attached Documentation)</p>	<p>6/25/07 and ongoing</p> <p>6/7/07 and ongoing</p> <p>6/7/07 and ongoing</p>

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I 379	Continued From page 7  21, 2006, staff received a call from the physical therapist that Client #2 bumped into a tree while on a walk. Client #2 was later dropped off to the group home with a band aid on her left leg. There was no evidence that an investigation was conducted.  3. The facility failed to demonstrate that a comprehensive investigation had been conducted to determine the circumstances surrounding the incident report dated November 10, 2006, Client #1 and #3 was involved in a vehicle accident with direct care staff who were driving. Both client were taken to a local hospital emergency room for evaluation and treatment.	I 379	3. On May 5, 2007 the QMRP followed-up with agency's Incident Management Team to ensure that a complete investigation was conducted to determine the circumstances surrounding the incident report dated November 10 <sup>th</sup> 2006, involving direct care staff and Client's #1 and #3 emergency room visit. (See Attached Documentation)	5/5/07 and Ongoing	
I 458	3521.11 HABILITATION AND TRAINING  Each resident 's activity schedule shall be available to direct care staff and be carried out daily.  This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure each resident's activity schedule was up to date and current for direct care staff implementation.  The finding includes:  See Federal Deficiency Report - Citations W250	I 458	1458  The QA Director has evaluated each client in the homes active treatment schedule to ensure that appropriately identifies the IPP Goals. Additionally the QA director has scheduled a meeting with all QMRP's on May 31, 2007 to review the guidelines of active treatment and delivery of services as agreed upon in the client's service plan. A copy of the Agenda and sign-in sheet can be found at our main office in the QA Department.	5/31/07 and Ongoing	